STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165538	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Ridge Care Center	1005 7th Street NE Orange City, IA 51041

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 1 residents reviewed for abuse (Resident #1). The facility reported a census of 83 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of dementia, anxiety disorder and non-traumatic brain dysfunction. The MDS identified the presence of short and long-term memory impairment. The Progress Note dated 4/27/2024 at 6:20 PM composed by Staff A documented the following: CNA approached this writer and stated she heard another CNA admit to doing something to a resident on the previous day, April 26th, while giving him a shower. CNA stated the other CNA said that while she was giving him a shower he became very aggressive and started swinging at her. CNA stated she put the showerhead spraying water on his face. Supposed CNA who took this action was already off shift when the CNA approached this writer to explain the conversation that took place. Call placed to DON. The untitled facility investigation completed by the Director of Nursing (DON) indicated on 4/27/24 at 6:15 PM the DON received a phone call from Charge Nurse, Staff A, Licensed Practical Nurse (LPN) with an alleged report from Staff B, Certified Nursing Assistant (CNA) that Staff B overhead Staff C, CNA tell Staff D, CNA while showering Resident #1 Staff C sprayed and held water on Resident #1 ' s face because the resident spat on Staff C. The facility investigation indicated next the DON called Staff C. Staff C stated, I would not do that. I know it is wrong. Staff C explained the resident did not spit on her during the shower. Staff C reported while washing Resident #1 ' s hair he attempted to hit her which caused the water to go in the resident's face and stunned him. Staff C reported she did not hold water to the resident ' s face. Staff C reported she moved the water away from the resident ' s face. In an interview on 11/25/24 at 9:43 AM, Staff B, CNA reported on approximately 4/27/24 while in the dining room Staff C, CNA informed a group of CNAs she was tired of Resident #1 spitting in her face. Staff C told the CNAs during his bath she sprayed Resident #1 in the face using the shower head. Staff B reported the conversation to Staff A, who then reported the incident to the DON. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/25/24 at 10:56 AM, Staff C, CNA, stated Resident #1 appeared to be agitated during the bath.Staff C sat the radio on the counter nearby in case she needed help. Staff C reported during the bath she tried to get away from the resident because he attempted to hit her. As the resident attempted to hit Staff C the shower head sprayed him in the face. Staff C stated, I wasn ' t trying to be mean or anything. Staff C then told Staff D, CNA what happened. Later the same day Staff B, CNA overheard Staff D, tell Staff E, CNA. Staff C stated, Staff B took it in the wrong context. The DON called Staff C to find out what happened. In an interview on 11/25/24 at 11:19 AM, The DON reported during the investigation she discovered a CNA overheard a conversation between two other CNA ' s. During the follow up Staff C, CNA explained while giving the resident a bath, his movements caused the shower head to spray him in the face. Staff C immediately redirected the spray away from his face. The DON reported having no other issues of allegations against Staff C and no resident complaints. The DON relayed she did not report the incident to DIAL because she felt there had been miscommunication between the CNA ' s. Staff B, CNA overheard the conversation between two CNAs about what Staff C said and misheard the facts. The DON reported Staff C continued to work in the same cottage because the DON determined abuse did not occur. The DON stated, We did end up assigning Staff C to another cottage. Staff C currently doesn ' t have anything to do with the resident. The Abuse Prevention and Response policy last revised on 10/14/24 identified reporting any suspicious injury and/or allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, missing money or property, or misappropriation of assets is to be reported immediately to the Nurse, Cottage Leader, DON or Administrator. If reported to the charge nurse or Cottage Leader, that person is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury. A report shall be made by calling the Department of Inspections and Appeals reporting hotline at (877) [PHONE NUMBER], submitting an e-mail to the Department at HFD_Complaint@dia.iowa.gov. submitting an online report or sending a fax to (515) [PHONE NUMBER]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the Department immediately, pursuant to the deadlines established above. If the allegations of dependent adult abuse involve a caretaker who is not an employee of the facility (e.g. family member, visitor), a report must also be made immediately to both the Iowa Department of Inspections & Appeals and the Iowa Department of Human Services (DHS) by phone call [PHONE NUMBER] and follow-up documentation is to be submitted to DIA and DHS as requested by DHS or if there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility, the Elder Justice Act requires the matter must also be reported to law enforcement. While the federal regulations require all abuse allegations be reported to DIA within 2 hours, the Elder Justice Act has a different time frame for reporting to the police/sheriff. If the allegation of abuse (that results from a crime) results in serious bodily injury to a resident, a report must be made to law enforcement not later than two (2) hours after the allegation is made. Investigation Protocols- Should an incident or suspected incident of Resident abuse (as defined above) be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. The facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: Suspending the employee Segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. And in rare instances separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents. The administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. Review documentation in resident record (including review of assessment if resident injury). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident for injury if the allegation involves physical or sexual abuse; Provide proper notifications to primary care provider, responsible party, etc. Attempt to obtain witness statements (oral and/or written) from all known witnesses. If there is physical evidence that can be preserved, attempt to do so, and maintain [NAME] safe location to minimize risk of evidence being tampered with. Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the Department of Inspections & Appeals. This written report shall be forwarded to the Department within five days of the initial report. Following completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee may be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the Department concludes its investigation and issues the written results of its investigation. NOTE: if the DIA determines there was abuse (even though the facility did not substantiate the abuse), there is risk that DIA could cite the facility with Immediate Jeopardy, for allowing an abuser to have access to other residents while the matter was being investigated. In an interview on 11/26/24 at 12:40 PM, the DON reported a was not made to DIAL because the DON felt the CNA ' s had a miscommunication and determined no abuse occurred. The DON reported she now planned to report all allegations of abuse to DIAL.